		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023093

Facility Name: BALLARD NURSING CENTER

Address: 9300 BALLARD ROAD (Number) DES PLAINES (City) 60016 (Zip Code)

County:

Telephone Number: 847 294-2300 **Fax #** 847 827-0981

IDPA ID Number: 36-2897326

Date of Initial License for Current Owners: 1/1/1977

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARK PICK
(Title) VICE PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number BALLARD NURSING CENTER INC # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	231	Skilled (SNF)	231	84,315	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			5,539	5,539	8
9	SNF/PED					9
10	ICF	30,500	8,160	3,988	42,648	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,500	8,160	9,527	48,187	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.15%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
OUTPATIENT

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 25 and days of care provided 5,539

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	266,635	23,770	10,262	300,667		300,667	0	300,667			1
2	Food Purchase		186,222		186,222		186,222	(5,803)	180,419			2
3	Housekeeping	198,095	37,580	0	235,675		235,675	0	235,675			3
4	Laundry	93,381	21,774	0	115,155		115,155	0	115,155			4
5	Heat and Other Utilities			205,669	205,669		205,669	0	205,669			5
6	Maintenance	80,363		78,498	158,861		158,861	0	158,861			6
7	Other (specify):*			25,050	25,050		25,050	0	25,050			7
8	**TOTAL General Services**	638,474	269,346	319,479	1,227,299	0	1,227,299	(5,803)	1,221,496			8
	B. Health Care and Programs											
9	Medical Director	0		76,550	76,550		76,550	0	76,550			9
10	Nursing and Medical Records	2,441,606	67,911	332,260	2,841,777		2,841,777	0	2,841,777			10
10a	Therapy	426,784	1,646	9,030	437,460		437,460	0	437,460			10a
11	Activities	154,323	7,247	2,842	164,412		164,412	0	164,412			11
12	Social Services	86,512		0	86,512		86,512	0	86,512			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			881	881		881	0	881			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	3,109,225	76,804	421,563	3,607,592	0	3,607,592	0	3,607,592			16
	C. General Administration											
17	Administrative	96,151		260,000	356,151		356,151	(38,750)	317,401			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			98,158	98,158		98,158	18,948	117,106			19
20	Dues, Fees, Subscriptions & Promotions			63,943	63,943		63,943	(25,266)	38,677			20
21	Clerical & General Office Expenses	368,337	44,273	80,120	492,730		492,730	(75,626)	417,104			21
22	Employee Benefits & Payroll Taxes			538,244	538,244		538,244	(1,716)	536,528			22
23	Inservice Training & Education			4,905	4,905		4,905	0	4,905			23
24	Travel and Seminar			8,778	8,778		8,778	(3,415)	5,363			24
25	Other Admin. Staff Transportation			0	0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			120,920	120,920		120,920	0	120,920			26
27	Other (specify):*			27,210	27,210		27,210	(12,822)	14,388			27
28	**TOTAL General Administration**	464,488	44,273	1,202,278	1,711,039	0	1,711,039	(138,647)	1,572,392			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,212,187	390,423	1,943,320	6,545,930	0	6,545,930	(144,450)	6,401,480			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BALLARD NURSING CENTER #0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			39,458	39,458		39,458	428,541	467,999			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			144,601	144,601		144,601	683,791	828,392			32
33	Real Estate Taxes				0		0	368,457	368,457			33
34	Rent-Facility & Grounds			1,272,000	1,272,000		1,272,000	(1,272,000)	0			34
35	Rent-Equipment & Vehicles			24,562	24,562		24,562	0	24,562			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			1,480,621	1,480,621	0	1,480,621	208,789	1,689,410			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		319,150	555,379	874,529		874,529	0	874,529			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			126,473	126,473		126,473	0	126,473			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	319,150	681,852	1,001,002	0	1,001,002	0	1,001,002			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,212,187	709,573	4,105,793	9,027,553	0	9,027,553	64,339	9,091,892			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,652)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,140)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	125,828	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(1,427)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(724)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(250)	20		17
18	Fines and Penalties	(10,652)	21		18
19	Entertainment	0	20		19
20	Contributions	(8,711)	20		20
21	Owner or Key-Man Insurance	(1,716)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(27,210)	27		24
25	Fund Raising, Advertising and Promotional	(14,955)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,350)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(67,165)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,124)		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	84,463		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 84,463		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 64,339		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BALLARD NURSING CENTER

ID# 0023093

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	MARKETING SALARIES	(63,750)	21	2
3	MARKETING TRAVEL	(3,415)	24	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(67,165)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,803)	0	0	0	0	0	0	0	0	0	0	(5,803)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,803)	0	0	0	0	0	0	0	0	0	0	(5,803)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(38,750)	0	0	0	0	0	0	0	0	(38,750)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,250	10,698	0	0	0	0	0	0	0	0	18,948	19
20	Fees, Subscriptions & Promotions	(25,266)	0	0	0	0	0	0	0	0	0	0	(25,266)	20
21	Clerical & General Office Expenses	(82,542)	0	6,916	0	0	0	0	0	0	0	0	(75,626)	21
22	Employee Benefits & Payroll Taxes	(1,716)	0	0	0	0	0	0	0	0	0	0	(1,716)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,415)	0	0	0	0	0	0	0	0	0	0	(3,415)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(27,210)	0	14,388	0	0	0	0	0	0	0	0	(12,822)	27
28	**TOTAL General Administration**	(140,149)	8,250	(6,748)	0	0	0	0	0	0	0	0	(138,647)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(145,952)	8,250	(6,748)	0	0	0	0	0	0	0	0	(144,450)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	125,828	301,457	1,256	0	0	0	0	0	0	0	0	428,541	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	683,791	0	0	0	0	0	0	0	0	0	683,791	32
33	Real Estate Taxes	0	368,457	0	0	0	0	0	0	0	0	0	368,457	33
34	Rent-Facility & Grounds	0	(1,272,000)	0	0	0	0	0	0	0	0	0	(1,272,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	125,828	81,705	1,256	0	0	0	0	0	0	0	0	208,789	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(20,124)	89,955	(5,492)	0	0	0	0	0	0	0	0	64,339	45

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Eli Pick	32.50%	N/A		Ballard Partners	Des Plaines, Il	Bldg Ownership
Moshe Pick	35.00%			Pick Management Group		Mgmt Company
Hadassah Pick	20.00%					
Sarah Fitterman	10.00%					
Gloria Pruzan	2.50%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 1,272,000	BALLARD PARTNERS		$	$ (1,272,000)	1
2	V								2
3	V	19	ACCOUNTING FEES		" " "		8,250	8,250	3
4	V	30	DEPRECIATION		" " "		301,457	301,457	4
5	V	32	INTEREST		" " "		683,791	683,791	5
6	V	33	REAL ESTATE TAX		" " "		368,457	368,457	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,272,000			$ 1,361,955	$ * 89,955	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 260,000	PICK MANAGEMENT	100.00%	$	$ (260,000)	15
16	V								16
17	V	17	SALARIES		" " "		221,250	221,250	17
18	V	19	ACCOUNTING FEES		" " "		9,670	9,670	18
19	V	19	DATA PROCESSING		" " "		1,028	1,028	19
20	V	21	OFFICE EXPENSE		" " "		6,916	6,916	20
21	V	27	PAYROLL TAXES		" " "		14,388	14,388	21
22	V	30	DEPRECIATION		" " "		1,256	1,256	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 260,000			$ 254,508	$ * (5,492)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	MOHE PICK	EXECUTIVE DIR	ADMINISTRATIV	35.00	NONE	40	100.00	SALARY	$ 109,375	17-7	1
2	ELI PICK	EXECUTIVE DIR	ADMINISTRATIV	32.50	NONE	40	100.00	SALARY	109,375	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 218,750		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	ALLFIRST		X	MORTGAGE	$44,927.00	5/91	$ 4,500,000	$ 9,438,601	8/34	10.5000	$ 683,791	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL							129,119	6
7	CAPITALIZE LEASES		X	EQUIPMENT							12,333	7
8	INSURANCE FINANCING		X	INSURANCE							3,149	8
9	TOTAL Facility Related				$44,927.00		$ 4,500,000	$ 9,438,601			$ 828,392	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 4,500,000	$ 9,438,601			$ 828,392	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	360,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	360,457	2
3. Under or (over) accrual (line 2 minus line 1).	$	457	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	368,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	368,457	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	331,607	8
	1997	335,298	9
	1998	352,039	10
	1999	355,679	11
	2000	360,457	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BALLARD NURSING CENTER COUNTY 0

FACILITY IDPH LICENSE NUMBER 0023093

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-303-013-0000	NURSING HOME	$ 360,456.61	$ 360,456.61
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 360,456.61	$ 360,456.61

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 770,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$ 0	3

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	231		1991	1973	$ 2,851,196	$ 96,569	35	$ 90,514	$ (6,055)	$ 1,005,753	4
5				1994	995,072	25,514	35	25,514		194,552	5
6				1994	986,459	25,293	35	25,293		180,220	6
7				1995	101,526	2,603	35	2,603		17,028	7
8											8
	Improvement Type**										
9	VARIOUS			1980	2,955		20			2,947	9
10	VARIOUS			1981	11,619		20			11,558	10
11	VARIOUS			1982	17,413		20			17,408	11
12	VARIOUS			1984	3,536		20			3,536	12
13	VARIOUS			1985	8,040		20			8,040	13
14	VARIOUS			1986	18,668	739	20	983	244	15,235	14
15	VARIOUS			1987	42,109	722	20	1,413	691	39,693	15
16	VARIOUS			1988	15,834	350	20	373	23	14,084	16
17	VARIOUS			1990	4,990	158	20	250	92	2,938	17
18	VARIOUS			1991	155,172	7,261	20	8,760	1,499	91,710	18
19	VARIOUS			1992	54,689	1,274	20	2,734	1,460	25,775	19
20	VARIOUS			1993	1,571	50	20	77	27	674	20
21	HEATING COOLING SYSTEM			1996	2,312	59	20	116	57	648	21
22	INTERIOR SIGNS			1996	350	9	20	18	9	100	22
23	BUILDING IMPROVEMENT			1996	70,114	1,798	20	3,506	1,708	19,575	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AIR SYSTEM BALANCE	1996	$ 1,762	$ 45	20	$ 88	$ 43	$ 491	37
38	MAV MOTOR REPLACEMENT	1996	2,000	51	20	100	49	558	38
39	INTERIOR SIGNS	1996	663	17	20	33	16	184	39
40	DRAPES	1996	616	16	20	31	15	173	40
41	COMP STATION CABLE	1996	2,566	66	20	128	62	715	41
42	HEAT AND COOLING SYSTEM	1997	2,999		20	150	150	650	42
43	SEWAGE PUMP	1997	2,498	64	20	125	61	583	43
44	CAULKING	1998	5,845	150	20	292	142	925	44
45	RENOVATION PATIOS	1998	6,134	157	20	307	150	1,075	45
46	A/C REPAIRS	1998	2,124	54	20	106	52	380	46
47	PARKING LOT	1998		51	20		(51)		47
48	ALARM SYSTEM	1998	2,500	64	20	125	61	490	48
49	SEWAGE PUMP	1998	2,498	64	20	125	61	500	49
50	A/C COUPLINGS	1998	2,905	74	20	145	71	532	50
51	PATIO DOOR	1998	2,040	52	20	102	50	349	51
52	MOTOR	1998	1,544	40	20	77	37	295	52
53	SPRINKLER SYSTEM	1998	3,500	90	20	175	85	598	53
54	FAUCETS, COUPLINGS	1998	10,159	260	20	508	248	1,778	54
55	COMPRESSOR	1998	13,886	356	20	694	338	2,313	55
56	MEDICAL GAS PIPING	1999	124,600	3,195	20	6,230	3,035	17,133	56
57	ELECTRICAL WORK	1999	201,699	5,172	20	10,085	4,913	29,415	57
58	CHILLER REPLACEMENT	1999	76,355	1,958	20	3,818	1,860	10,181	58
59	AIR CARRIER	1999	693	18	20	35	17	73	59
60	CARPETING	1999	4,921	126	20	492	366	1,435	60
61	LOADING RAMP & PATIO	1999	127,175	3,261	20	6,359	3,098	17,487	61
62	SPRINKLER REPAIRS	1999	2,850	73	20	143	70	334	62
63	HEATING AND COOLING	1999	8,208	210	20	410	200	888	63
64	FLOW DEVICE OXYGEN	1999	1,760	45	20	88	43	235	64
65	ER GENER DESIGN	1999	11,614	298	20	568	270	1,704	65
66	DOOR CENSORS	1999	718	18	20	36	18	87	66
67	SIGNS	1999	18,235	468	20	912	444	2,432	67
68	METAL ENCLOSURE	1999	934	24	20	47	23	94	68
69	PARKING AND AISLE PAVE	1999	65,443	1,678	20	3,272	1,594	8,527	69
70	TOTAL (lines 4 thru 69)		$ 6,055,069	$ 180,614		$ 197,960	$ 17,346	$ 1,754,088	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,055,069	$ 180,614		$ 197,960	$ 17,346	$ 1,754,088	1
2	NURSE CALL SYSTEM	1999	49,222	1,262	20	2,461	1,199	6,358	2
3	LOAD RAMP-DESIGN	1999	14,368	368	20	718	350	1,975	3
4	DOOR LOCKS	1999	2,781	71	20	139	68	324	4
5	FIRE PANEL	1999	978	25	20	49	24	127	5
6	NURSE CALL SYSTEM	2000	49,221	1,262	20	2,256	994	4,512	6
7	KEYLESS ENTRY SYSTEM	2000	1,250	32	20	58	26	116	7
8	ELECTRICAL OUTLETS	2000	7,600	195	20	253	58	506	8
9	VENTILATION BOILER	2000	5,696	146	20	166	20	332	9
10	WEIL MCLAIN BOILER	2000	50,425	1,293	20	210	(1,083)	420	10
11	HOT WATER BOILER	2000	9,172	235	20	153	(82)	306	11
12									12
13	TELEPHONE SYSTEM	1999	83,381	59,367	20	16,676	(42,691)	38,911	13
14	TELEPHONE SYSTEM ENHANCEMENT	2000	1,716	892	10	172	(720)	344	14
15									15
16	PICK MGMT GROUP	1996	48,986	1,256	20		(1,256)	49,896	16
17									17
18									18
19	DIALYSIS SPACE/MEDICAL & GAS UPGRADES/REGULATO	2001	33,596	645	27.5	645		645	19
20	COOLING COIL REPLACEMENT	2001	24,604	485	27.5	485		485	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,438,065	$ 248,148		$ 222,401	$ (25,747)	$ 1,859,345	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 197,960	$ 39,458	$ 19,796	$ (19,662)	10	$	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets	93,318	0	0	0	10		73
74	RELATED PARTY	2,172,927	54,565	225,802	171,237			74
75	TOTALS	$ 2,464,205	$ 94,023	$ 245,598	$ 151,575		$ 0	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,902,270	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 342,171	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 467,999	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 125,828	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,859,345	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 22,150 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 51,119	$		$ 51,119	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,143			10,143	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			183,546			183,546	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				170,805		170,805	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Med Supp, Lab, Rentals, Resp, Oxygen Other (specify):	39-2 & 3					458,916		458,916	13
14	TOTAL			$		$ 244,808	$ 629,721		$ 874,529	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BALLARD NURSING CENTER **#** 0023093 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 122,564	$ 125,364	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 148,000)	2,554,817	2,554,817	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	177,532	208,771	6
7	Other Prepaid Expenses	31,245	31,245	7
8	Accounts Receivable (owners or related parties)	488,696	1,516,652	8
9	Other(specify): ESCROWS		785,692	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,374,854	$ 5,222,541	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		3,041,555	14
15	Leasehold Improvements, at Historical Cost		3,387,308	15
16	Equipment, at Historical Cost	291,277	2,549,301	16
17	Accumulated Depreciation (book methods)	(239,636)	(3,931,512)	17
18	Deferred Charges		433,576	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): LEASE DEPOSITS	3,944	3,944	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 55,585	$ 5,484,172	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,430,439	$ 10,706,713	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,274,686	$ 1,282,938	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,568	11,568	28
29	Short-Term Notes Payable	925,000	925,000	29
30	Accrued Salaries Payable	338,008	338,008	30
31	Accrued Taxes Payable (excluding real estate taxes)	61,933	61,933	31
32	Accrued Real Estate Taxes(Sch.IX-B)		368,000	32
33	Accrued Interest Payable	8,633	65,433	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Lease Payable	60,661	60,661	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,680,489	$ 3,113,541	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,094,484	1,094,484	39
40	Mortgage Payable		9,438,601	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,094,484	$ 10,533,085	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,774,973	$ 13,646,626	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (344,534)	$ (2,939,913)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,430,439	$ 10,706,713	48

***(See instructions.)**

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (126,721)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (126,721)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(217,813)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (217,813)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (344,534)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,415,511	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,415,511	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	367,131	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 367,131	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	11,751	13
14	Non-Patient Meals	3,652	14
15	Telephone, Television and Radio	8,140	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 23,543	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	899	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 899	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	2,656	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,656	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,809,740	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,227,299	31
32	Health Care	3,607,592	32
33	General Administration	1,711,039	33
	B. Capital Expense		
34	Ownership	1,480,621	34
	C. Ancillary Expense		
35	Special Cost Centers	874,529	35
36	Provider Participation Fee	126,473	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,027,553	40
41	**Income before Income Taxes (line 30 minus line 40)****	(217,813)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (217,813)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	1,984	$ 59,693	$ 30.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,466	26,185	638,368	24.38	3
4	Licensed Practical Nurses	27,457	30,166	439,092	14.56	4
5	Nurse Aides & Orderlies	89,133	94,610	1,286,354	13.60	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	20,420	21,988	426,784	19.41	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	14,083	15,740	154,323	9.80	10
11	Social Service Workers	5,527	6,101	86,512	14.18	11
12	Dietician					12
13	Food Service Supervisor	1,875	2,074	40,315	19.44	13
14	Head Cook	1,637	1,679	16,885	10.06	14
15	Cook Helpers/Assistants	15,706	17,180	151,004	8.79	15
16	Dishwashers	8,332	8,886	58,431	6.58	16
17	Maintenance Workers	4,161	4,433	80,363	18.13	17
18	Housekeepers	27,015	28,696	198,095	6.90	18
19	Laundry	9,715	10,905	93,381	8.56	19
20	Administrator					20
21	Assistant Administrator	1,907	2,034	96,151	47.27	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,607	20,146	368,337	18.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,922	2,117	18,099	8.55	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	272,923	294,924	$ 4,212,187 *	$ 14.28	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 10,262	1-3	35
36	Medical Director	Monthly	76,550	9-3	36
37	Medical Records Consultant	360 month	4,032	10-3	37
38	Nurse Consultant	Monthly	7,085	10-3	38
39	Pharmacist Consultant	780 month	9,360	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	Monthly	2,842	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify)				46
47	REHABILITATION CONSULTANT	Monthly	3,000	10a-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 113,131		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,923	$ 198,640	10-3	50
51	Licensed Practical Nurses	2,429	89,986	10-3	51
52	Nurse Aides	432	10,102	10-3	52
53	TOTAL (lines 50 - 52)	7,784	$ 298,728		53

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
	ADMIN		$ 0
SUSAN MICHAELS	ASST ADMIN		96,151
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,151

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 260,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 260,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		98,158
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 98,158

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,724
Unemployment Compensation Insurance	33,560
FICA Taxes	313,005
Employee Health Insurance	120,660
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	22,579
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	1,716
INSURANCE - EXECUTIVE LIFE VI 21	(1,716)
TOTAL (agree to Schedule V, line 22, col.8)	$ 536,528

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,991
Health Care Worker Background Check	2,775
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	16,305
TRUST FEES/FRANCHISE TX/ETC	250
CONTRIBUTIONS	8,711
DUES & SUBSCRIPTIONS	6,756
LICENSES & PERMITS	18,155
TRUST FEES/TAX/CONTRIBUTIONS	(8,961)
Less: Public Relations Expense	(0)
Non-allowable advertising	(14,955)
Yellow page advertising	(1,350)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,677

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	8,778
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,778

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILLINOIS COUNCIL ON LONG TERM CARE

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 5,473 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 126,473
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: BALLARD NURSING CENTER **#0023093** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	10,262	
	REPAIRS & MAINTENANCE		0	
			0	10,262
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		85,904	
	ELECTRICITY		81,061	
	WATER		38,704	
	CABLE TV - LOBBY		0	
			0	205,669
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		15,172	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		45,043	
	ELEVATOR MAINTENANCE & REPAIR		541	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		150	
	CONTRACTED BLDG MAINT		17,592	
			0	
			0	78,498
7	**OTHER**			
	SCAVENGER & EXTERMINATOR		25,050	
	SECURITY SERVICE		0	25,050
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	76,550	76,550

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	298,728	
	LABORATORY & XRAY EXPENSE		13,055	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,032	
	PHARMACY CONSULTANT	XVIII B 39-2	9,360	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	7,085	
			0	332,260
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		2,143	
	SPEECH THERAPY SERVICES		3,887	
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B 47-2	3,000	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	9,030
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,842	
			0	2,842
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BALLARD NURSING CENTER **#0023093** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		881	881
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	260,000	260,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	28,195	
	ADMINISTRATIVE CONSULTANTS	XIX C	7,210	
	PROFESSIONAL FEES	XIX C	62,753	
			0	98,158
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	14,955	
	EMPLOYEE WANT ADS	XIX F	10,991	
	CONTRIBUTIONS	VI 20 XIX F	550	
	DUES & SUBSCRIPTIONS	XIX F	6,756	
	LICENSES & PERMITS	XIX F	18,155	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,350	
	TRUST FEES	VI 17 XIX F	250	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	8,161	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,775	63,943
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		0	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES/BANK CHARGES	VI 18	10,652	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		66,538	
	MESSENGER SERVICE		0	
	COMPUTER EXPENSE		2,930	80,120

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	313,005	
	UNEMPLOYMENT COMPENSATION	XIX D	33,560	
	WORKERS COMPENSATION INSURANC	XIX D	46,724	
	HOSPITALIZATION INSURANCE	XIX D	120,660	
	EMPLOYEE BENEFITS - OTHER	XIX D	22,579	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	1,716	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	538,244
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,905	4,905
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	8,778	
			0	
			0	8,778
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		0	0
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		120,920	120,920
27	**OTHER**			
	BAD DEBTS	VI 24	27,210	
			0	27,210

GRAND TOTAL COLUMN 3 OTHER 1,943,320

BALLARD NURSING CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	186,222	PATIENT MEALS	144561
LESS SALES TAX	(724)	ADD EMPLOYEE MEALS	0
NET FOOD	186946	TOTAL MEALS/YEAR	144561
TOTAL PATIENT CENSUS	48,187	NET FOOD	186946
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	144561
TOTAL PATIENT MEALS	144561	COST PER MEAL	1.29
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		